



IDAHO DEPARTMENT OF
HEALTH & WELFARE

COPY

C. L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888

Certified Mail: 7007 0710 0002 7979 0642

November 19, 2009

Thair Pond
Tomorrow's Hope - Armga
1655 Fairview Avenue, Suite 100
Boise, ID 83702

RE: Tomorrow's Hope - Armga, Provider #13G014

Dear Mr. Pond:

Based on the Medicaid/Licensure survey completed at Tomorrow's Hope - Armga on November 9, 2009, by our staff, we have determined that Tomorrow's Hope - Armga is out of compliance with the Medicaid Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) Condition of Participation on Active Treatment Services (42 CFR 483.440). To participate as a provider of services in the Medicaid program, an ICF/MR must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies which caused this Condition to be unmet, substantially limit the capacity of Tomorrow's Hope - Armga to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). A similar form indicates State Licensure deficiencies.

You have an opportunity to make corrections of those deficiencies which led to the finding of non-compliance with the Condition of Participation referenced above by submitting a written Credible Allegation of Compliance. Such corrections must be achieved and compliance verified, by this office, before **December 24, 2009**. **To allow time for a revisit to verify corrections prior to that date, your Credible Allegation must be received in this office no later than December 15, 2009.**

The following is an explanation of a credible allegation:

Credible allegation of compliance. A credible allegation is a statement or documentation:

- Made by a provider/supplier with a history of having maintained a commitment to compliance and taking corrective actions if required.
- That is realistic in terms of the possibility of the corrective actions being accomplished between the exit conference and the date of the allegation, and
- That indicates resolution of the problems.

In order to resolve the deficiencies the facility must submit a letter of credible allegation to the Department, which contains a sufficient amount of information to indicate that a revisit to the facility will find the problem corrected.

As mentioned above, the letter of credible allegation must indicate that the problems have been corrected as of the date the letter is signed. Hence, a plan of correction indicating that the correction(s) will be made in the future would not be acceptable. Please keep in mind that once the Department receives the letter of credible allegation, an unannounced visit could be made at the facility at any time.

Failure to correct the deficiencies and achieve compliance will result in our recommending that the Medicaid Agency terminate your approval to participate in the Medicaid Program. If you fail to notify us, we will assume you have not corrected.

Also, pursuant to the provisions of IDAPA 16.03.11.320.04, Tomorrow's Hope - Armga ICF/MR is being issued a Provisional Intermediate Care Facility for Persons with Mental Retardation license. The license is enclosed and is effective November 9, 2009, through March 9, 2010. The conditions of the Provisional License are as follows:

1. Post the provisional license.
2. Correct all cited deficiencies and maintain compliance.

Please be aware that failure to comply with the conditions of the provisional license may result in further action being taken against the facility's license pursuant to IDAPA 16.03.11.350.

Be advised, that, consistent with IDAPA 16.05.03.300, you are entitled to request an administrative review regarding the issuance of the provisional license. To be entitled to an administrative review, you must submit a written request by **December 17, 2009**. The request must state the grounds for the facility's contention of the issuance of the provisional license. You should include any documentation or additional evidence you wish to have reviewed as part of the administrative review.

Your written request for administrative review should be addressed to:

Randy May, Deputy Administrator
Division of Medicaid -- DHW
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 364-1804
fax: (208) 364-1811

If you fail to submit a timely request for administrative review, the Department of Health and Welfare's decision to issue the provisional license becomes final. Please note that issues which are not raised at an administrative review may not later be raised at higher level hearings (IDAPA 16.05.03.301).

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

<http://www.healthandwelfare.idaho.gov/site/3633/default.aspx>

This request must be received by December 2, 2009. If a request for informal dispute resolution is received after December 2, 2009 the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

We urge you to begin correction immediately. If you have any questions regarding this letter or the enclosed reports, please contact me at (208) 334-6626.

Sincerely,



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

NW/mlw

Enclosures



TOMORROW'S HOPE, INC.

1655 FAIRVIEW AVENUE, SUITE 100
BOISE, ID 83702

PHONE: (208) 319-0760

FAX: (208) 319-0765

Nicole Wisenor
Co-Supervisor
Non Long Term Care
Bureau of Facility Standards
PO Box 83720
Boise, Idaho 83720-0036

RECEIVED

DEC 01 2009

24 November 2009

FACILITY STANDARDS

RE: Statement of Corrections for Armga ICF/MR

Dear Ms. Wisenor,

Please accept this as our letter of Credible Allegation that corrections of deficiencies found during the recent survey of our Armga ICF/MR have been or will be made by 12/11/09.

We believe we have made corrections and will be ready for your survey to assure compliance. If you have any questions, please call me at the above numbers.

Sincerely,

Thair Pond
Administrator

Incl.
CC file, Armga,

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/18/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/09/2009
NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - ARMGA			STREET ADDRESS, CITY, STATE, ZIP CODE 12306 WEST ARMGA DRIVE MERIDIAN, ID 83642	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey. The survey was conducted by: Monica Williams, QMRP, Team Lead Amy Petersen, QMRP Common abbreviations/symbols used in this report are: ADHD - Attention Deficit Hyperactivity Disorder IPP - Individual Program Plan LPN - Licensed Practical Nurse PQ - Para Qualified Mental Retardation Professional QMRP - Qualified Mental Retardation Professional	W 000	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">DEC 01 2009</p> <p style="text-align: center;">FACILITY STANDARDS</p>	
W 100	440.150(c) ICF SERVICES OTHER THAN IN INSTITUTIONS "Intermediate care facility services" may include services in an institution for the mentally retarded (hereafter referred to as intermediate care facilities for persons with mental retardation) or persons with related conditions if: (1) The primary purpose of the institution is to provide health or rehabilitative services for mentally retarded individuals or persons with related conditions; (2) The institution meets the standards in Subpart E of Part 442 of this Chapter; and (3) The mentally retarded recipient for whom payment is requested is receiving active treatment as specified in §483.440. This STANDARD is not met as evidenced by: Based on observation, record review, and staff	W 100		W100 Refer to Tag W195

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Thair Pond Administrator, 11/24/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 100	Continued From page 1 interviews it was determined each recipient for whom payment was requested was not receiving active treatment as specified in 483.440. The findings include:	W 100			
W 195	1. Refer to W195 - Condition of Participation for Active Treatment Services not met and related standard level deficiencies. 483.440 ACTIVE TREATMENT SERVICES The facility must ensure that specific active treatment services requirements are met.	W 195	W195 Refer to Tag W196 and Tag W249		
W 196	This CONDITION is not met as evidenced by: Based on observations, record review, and staff interviews it was determined the facility failed to ensure active treatment services were provided to each individual participating in the facility's program. This resulted in a lack of involvement in activities which addressed individuals' priority needs and a lack of opportunities to practice new or existing skills. The findings include: 1. Refer to W196 as it relates to the facility's failure to ensure individuals were provided with a continuous active treatment program. 2. Refer to W249 as it relates to the facility's failure to ensure individuals received training and services consistent with their IPPs. 483.440(a)(1) ACTIVE TREATMENT Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this	W 196			

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W 196	<p>Continued From page 2</p> <p>subpart, that is directed toward:</p> <p>(i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and</p> <p>(ii) The prevention or deceleration of regression or loss of current optimal functional status.</p> <p>This STANDARD is not met as evidenced by: Based on observations, record review, and staff interviews it was determined the facility failed to ensure each individual was provided with continuous and consistent active treatment services in all relevant settings for 4 of 5 individuals (Individuals #1, #2, #4 and #5) whose IPPs and training programs were reviewed. That failure resulted in individuals not receiving training and services necessary to promote independence and maximize their developmental potential. The findings include:</p> <p>1. Individual #1's IPP, dated 7/8/09, documented a 27 year old female diagnosed with profound mental retardation, autism, seizure disorder, and left hemiparesis.</p> <p>Observations were conducted at the facility on 11/3/09 and 11/4/09 for a cumulative 4 hours 23 minutes during the day shift with the following results:</p> <p>a. An observation was conducted on 11/3/09 from 1:50 - 2:47 p.m. During that time, Individual #1 was not observed to participate in skill-building or meaningful activity as follows:</p> <p>1:50 - 2:15 p.m.: Individual #1 was observed sitting on the couch in the back living room listening to an iPod (portable music player) with</p>	W 196	<p>W196</p> <p>Staff trained to ensure each resident is provided with continuous and consistent active treatment. Staff to read current Survey and reinact what could be done different for each deficiency to be in compliance. PQ and Q trained during staff meetings and during observations and training on the floor to ensure staff understand how to provide active treatment.</p> <p>Para Q and Q responsible by 11/24/09</p> <p>PQ, Q, and other professional staff to observe at least weekly and train staff how to provide active treatment. Observations, corrections, and training to be documented using PSRs. PSR are to be reviewed during monthly QA reviews and needed corrections to be added to Action list to be corrected by next QA review</p> <p>PQ and Q responsible by 12/11/09</p>	

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W 196	<p>Continued From page 3</p> <p>earphones on. Intermittently, she was noted to rock back and forth. Staff was noted to verbally prompt her two times to pull her shirt down to cover her stomach. She did not respond and staff pulled her shirt down for her.</p> <p>2:15 - 2:17 p.m.: Individual #1 stood up while listening to her iPod and paced briefly in front of the kitchen sliding door.</p> <p>2:17 - 2:50 p.m.: Individual #1 returned to the back living room resuming her previous position on the couch, and listened to her iPod. She was not offered or encouraged to participate in any other skill-building or meaningful activity.</p> <p>During the 57 minute observation, Individual #1 was not engaged in functional activity. Her Daytreatment Schedule, dated 10/09, stated she was to be offered activities every 15 minutes to encourage her to socialize.</p> <p>When asked about the observation, the QMRP stated during interview on 11/6/09 from 1:50 - 3:45 p.m., all staff had been trained that "Every opportunity is a learning opportunity and individuals should be encouraged to participate in all activities of daily living to the fullest extent of their abilities." The QMRP stated formal and informal training as identified in her IPP and Medical and Social Assessment should have been implemented. The QMRP stated she believed the staff were nervous.</p> <p>b. An observation was conducted on 11/4/09 from 7:47 - 9:02 a.m. During that time, Individual #1 was not observed to participate in skill-building or meaningful activity as follows:</p>	W 196			

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W 196	<p>Continued From page 4</p> <p>7:47 - 8:15 a.m.: Individual #1 was observed sitting on the couch in the back living room listening to her iPod with earphones on. Intermittently, she would rock back and forth while listening to music. She was asked two times (at 7:48 a.m. and 8:07 a.m.) if she wanted to eat breakfast. She did not respond. The staff person informed her they would come back in five minutes after the 7:48 a.m. interaction. The staff was not noted to return until 8:07 a.m.</p> <p>Further, at 8:07 a.m., a second staff person was noted to be laundering Individual #1's bedding. When asked, the staff person stated she (Individual #1) had soiled her bed during the night. Individual #1 was not prompted or encouraged to change her bed linens or assist with laundering them.</p> <p>8:15 - 8:32 a.m.: (survey team in medication room).</p> <p>8:32 - 9:02 a.m.: Individual #1 was observed sitting on the couch in the back living room listening to her iPod. Intermittently, she would rock back and forth while listening to music. She was not offered or encouraged to participate in any other skill-building or meaningful activity.</p> <p>During the 58 minutes that Individual #1 was observed, she was not noted to be engaged in functional activities.</p> <p>When asked about the observation, the QMRP stated during interview on 11/6/09 from 1:50 - 3:45 p.m., formal and informal training as identified in her IPP and Medical and Social Assessment should have been implemented. The QMRP stated she believed the staff were</p>	W 196			

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W 196	<p>Continued From page 5 nervous.</p> <p>2. Individual #2's IPP, dated 3/26/09, documented a 27 year old male diagnosed with moderate mental retardation, autism, cerebral palsy, Fetal Alcohol Syndrome, and seizure disorder.</p> <p>Observations were conducted at the facility on 11/3/09 and 11/4/09 for a cumulative 4 hours 23 minutes during the day shift with the following results:</p> <p>a. An observation was conducted on 11/3/09 from 1:50 - 2:47 p.m. During that time, Individual #2 was not observed to participate in skill-building or meaningful activity as follows:</p> <p>1:50 - 1:58 p.m.: Individual #2 was noted to be sitting on the couch in the television room, holding a magazine.</p> <p>1:58 - 2:08 p.m. Individual #2 was noted to stand and walk to the front living room. He sat on the couch and held his magazine.</p> <p>2:08 - 2:20 p.m.: Individual #2 was noted to stand and walk to the television room. He sat on the couch and held his magazine.</p> <p>2:20 - 2:43 p.m. Individual #2 was noted to stand and walk to the front living room. He sat on the couch and held his magazine. At 2:24 p.m., the PQ, who was present, was noted to read a book to him that ended at 2:28 p.m. Individual #2 was noted to continue to sit on the couch and hold his magazine.</p> <p>2:43 - 2:47 p.m.: Individual #2 was noted to stand and walk to the kitchen. Staff offered him toast</p>	W 196			

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W 196	<p>Continued From page 6</p> <p>and coffee and he did not respond. Individual #2 was noted to walk to the television room. He sat on the couch and held his magazine.</p> <p>During the 57 minute observation, Individual #2 was engaged in functional activity for a total of 4 minutes (attending to a story being read to him).</p> <p>When asked about the observation, the QMRP stated during interview on 11/6/09 from 1:50 - 3:45 p.m., all staff had been trained that "Every opportunity is a learning opportunity and individuals should be encouraged to participate in all activities of daily living to the fullest extent of their abilities." The QMRP stated formal and informal training as identified in his IPP and Medical and Social Assessment should have been implemented. The QMRP stated she believed the staff were nervous.</p> <p>b. An observation was conducted on 11/4/09 from 8:15 - 9:00 a.m. During that time, Individual #2 was not observed to participate in skill-building or meaningful activity as follows:</p> <p>8:15 - 8:33 a.m.: Individual #2 came in to the kitchen, obtained a bowl and spoon, and went into the medication room.</p> <p>8:33 - 8:42 a.m.: Individual #2 was verbally prompted to put his bowl and spoon in the kitchen sink which he did. With a verbal prompt, he placed a serving of oatmeal in a bowl. He then left the kitchen and went in to the television room. At 8:37 a.m., he walked back to the kitchen and poured himself a glass of milk. He then left the kitchen and proceeded to wander between the living room and the television room.</p>	W 196			

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W 196	<p>Continued From page 7</p> <p>8:42 - 8:46 a.m.: Individual #2 was physically assisted to the dining table and a staff offered him his bowl of oatmeal. It was noted that yogurt and three apple slices were added to the top of the oatmeal. Individual #2 stood, left the table, and proceeded to wander between the television room, his bedroom, and the living room.</p> <p>8:46 - 8:53 a.m.: Individual #2 was verbally prompted to go to the television room, which he did. Once in the room, a staff was noted to place a chair in the entrance such that Individual #2 could not leave the room. Individual #2 was noted to wander around the room.</p> <p>8:53 - 9:00 a.m.: Individual #2 was verbally prompted to go in the medication room, which he did.</p> <p>During the 45 minute observation, Individual #2 was engaged in functional activity for a total of 26 minutes (administration of medications and served self breakfast items).</p> <p>When asked about the observation, the QMRP stated during interview on 11/6/09 from 1:50 - 3:45 p.m., formal and informal training as identified in his IPP and Medical and Social Assessment should have been implemented. The QMRP stated she believed the staff were nervous.</p> <p>c. An observation was conducted on 11/4/09 from 11:24 a.m. - 12:50 p.m. During that time, Individual #2 was not observed to participate in skill-building or meaningful activity as follows:</p> <p>11:24 - 11:30 a.m.: Individual #2 was sitting on the couch in the television room. At 11:25 a.m.,</p>	W 196		

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W 196	<p>Continued From page 8</p> <p>he was physically assisted to the living room in order to play a board game. He sat at the table in the living room. He was not noted to participate in the game.</p> <p>11:30 - 11:38 a.m.: Individual #2 stood and obtained a magazine which was lying on the table. He took the magazine and proceeded to the television room. At 11:33 a.m., he walked in to the kitchen where he was verbally prompted to go to the living room as staff was preparing lunch. He walked into the living room and sat at the table. He was verbally prompted to spin the dial on the board game which he did. He was verbally prompted two additional times to spin the dial, which he did.</p> <p>11:38 - 11:54 a.m.: Individual #2 left the table and sat on the couch, holding a magazine.</p> <p>11:54 - 11:56 a.m.: Individual #2 stood and walked to the television room where he sat on the couch, holding his magazine.</p> <p>11:56 a.m. - 12:03 p.m.: Individual #2 stood and walked to the living room where he sat on the couch, holding his magazine. At 12:01 p.m., he was verbally prompted to go outside with staff. He did not respond.</p> <p>12:03 - 12:08 p.m.: Individual #2 stood and walked to the television room where he sat on the couch, holding his magazine.</p> <p>12:08 - 12:15 p.m.: Individual #2 stood and walked to the living room where he sat on the couch, holding his magazine.</p> <p>12:15 - 12:17 p.m.: Individual #2 stood and</p>	W 196			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/09/2009
NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - ARMGA			STREET ADDRESS, CITY, STATE, ZIP CODE 12306 WEST ARMGA DRIVE MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 196	<p>Continued From page 9</p> <p>walked to the television room and back to the living room, where he sat on the couch, holding his magazine.</p> <p>12:17 - 12:35 p.m.: Individual #2 was prompted to sit at the dining table which he did. He was verbally prompted to place a serving of macaroni and cheese and a hot dog on his plate which he did. He poured himself a glass of milk. He proceeded to eat lunch. He was not noted to be prompted or encouraged to wash his hands or assist in preparing his lunch.</p> <p>12:35 - 12:43 p.m.: Individual #2 was noted to have finished eating. With verbal prompts, he took his dishes to the kitchen counter and then proceeded to the bathroom.</p> <p>12:43 - 12:50 p.m.: Individual #2 came out of the bathroom and proceeded to the living room where he sat on the couch.</p> <p>During the 1 hour 26 minute observation, Individual #2 was engaged in functional activity for a total of 26 minutes (ate lunch, bussed his dishes, and used the restroom).</p> <p>When asked about the observation, the QMRP stated during interview on 11/6/09 from 1:50 - 3:45 p.m., formal and informal training as identified in his IPP and Medical and Social Assessment should have been implemented. The QMRP stated she believed the staff were nervous.</p> <p>3. Individual #4's IPP, dated 9/11/09, documented a 28 year old male diagnosed with profound mental retardation, ADHD, and autism.</p>	W 196			

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W 196	<p>Continued From page 10</p> <p>Observations were conducted at the facility on 11/3/09 and 11/4/09 for a cumulative 4 hours 23 minutes during the day shift with the following results:</p> <p>a. An observation was conducted on 11/3/09 from 1:50 - 2:47 p.m. During that time, Individual #4 was not observed to participate in skill-building or meaningful activity as follows:</p> <p>1:50 - 1:55 p.m.: Individual #4 sat on the couch in the living room. He was noted to be wearing his coat.</p> <p>1:55 - 1:58 p.m.: Individual #4 went outside where he was noted to wander around the back yard.</p> <p>1:58 - 2:11 p.m.: Individual #4 came inside and went to the living room. He removed his coat and proceeded to wander between the living room, dining room, and television room.</p> <p>2:11 - 2:20 p.m.: Individual #4 walked outside. He was prompted to come in and get his coat which he did. He was physically assisted to zip his coat and proceeded back outside. He was noted to wander around the back yard.</p> <p>2:20 - 2:25 p.m.: Individual #4 came inside and went to the living room. He removed his coat and proceeded to wander between the living room, dining room, and television room.</p> <p>2:25 - 2:40 p.m.: Individual #4 went into his bedroom and came out with a magazine. He went to the living room and sat at a table, holding the magazine. At 2:28 p.m., he pointed to his coat and with a verbal prompt, he put it on and proceeded outside to the back yard. He was</p>	W 196			

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W 196	<p>Continued From page 11</p> <p>noted to wander around the yard, holding his magazine.</p> <p>2:40 - 2:44 p.m.: Individual #4 came inside and was prompted to sit at the dining table, which he did. Staff prepared an onion roll, cut in half, with three-cheese spread. Individual #4 was served his snack which he ate. He was not noted to be prompted or encouraged to wash his hands or assist in preparing his snack.</p> <p>2:44 - 2:47 p.m.: Individual #4 finished his snack. He was noted to put his plate in the sink and proceeded to wander between the living room, dining room, and television room.</p> <p>During the 57 minute observation, Individual #4 was engaged in functional activity for a total of 3 minutes (ate his snack).</p> <p>When asked about the observation, the QMRP stated during interview on 11/6/09 from 1:50 - 3:45 p.m., all staff had been trained that "Every opportunity is a learning opportunity and individuals should be encouraged to participate in all activities of daily living to the fullest extent of their abilities." The QMRP stated formal and informal training as identified in his IPP and Medical and Social Assessment should have been implemented. The QMRP stated she believed the staff were nervous.</p> <p>b. An observation was conducted on 11/4/09 from 7:34 - 9:00 a.m. During that time, Individual #4 was not observed to participate in skill-building or meaningful activity as follows:</p> <p>7:34 - 8:44 a.m.: Individual #4 was noted to be sitting on the couch in the living room, holding a</p>	W 196			

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W 196	<p>Continued From page 12 magazine.</p> <p>8:44 - 9:00 a.m.: Individual #4 was verbally prompted to go to the television room. He stood and wandered around the dining area. At 8:46 a.m., he went in to the television room and sat on the couch. A staff was noted to place a chair in the entrance such that Individual #4 could not leave the room.</p> <p>During the 1 hour 26 minute observation, Individual #4 was not engaged in functional activity.</p> <p>When asked about the observation, the QMRP stated during interview on 11/6/09 from 1:50 - 3:45 p.m., formal and informal training as identified in his IPP and Medical and Social Assessment should have been implemented. The QMRP stated she believed the staff were nervous.</p> <p>c. An observation was conducted on 11/4/09 from 11:24 a.m. - 12:50 p.m. During that time, Individual #4 was not observed to participate in skill-building or meaningful activity as follows:</p> <p>11:24 - 11:28 a.m.: Individual #4 was verbally prompted to remove his coat and go to the living room to play a board game. He proceeded to the living room and removed his coat. At 11:25 a.m., he sat at the table and waited for staff to set up the game.</p> <p>11:28 - 11:35 a.m.: Individual #4 was verbally prompted to choose a game piece which he did. He stood and walked to the bathroom. He returned to the table at 11:30 a.m. and sat. He was prompted to move his game piece 3 spaces</p>	W 196			

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W 196	<p>Continued From page 13</p> <p>on the game board, which he did in a random fashion. He was then verbally prompted to find two different cities on the board. He did not respond.</p> <p>11:35 - 11:45 a.m.: Individual #4 sat at the table in the living room.</p> <p>11:45 a.m. - 12:03 p.m.: Individual #4 was prompted to put on his coat which he did. At 11:46 a.m., he left the facility to go for a walk with staff.</p> <p>12:03 - 12:15 p.m.: Individual #4 returned to the facility. He went in to the television room, located a magazine, and sat on the couch.</p> <p>12:15 - 12:29 p.m.: Individual #4 went in to the living room and sat at the table. Lunch items were placed on the table, and at 12:17 p.m., Individual #4 was noted to place a serving of macaroni and cheese, a hot dog, fruit cocktail, and yogurt on his plate. He proceeded to eat lunch. He was not noted to be prompted or encouraged to wash his hands or assist in preparing his lunch.</p> <p>12:29 - 12:34 p.m.: Individual #4 was noted to have finished his lunch. He took his dishes to the kitchen sink and then went in to the bathroom.</p> <p>12:34 - 12:50 p.m.: Individual #4 came out of the bathroom. He proceeded to wander between the living room, dining area, and the television room.</p> <p>During the 86 minute observation, Individual #4 was engaged in functional activity for a total of 41 minutes (went for a walk, ate lunch, bussed his dishes, and used the restroom).</p>	W 196			

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W 196	<p>Continued From page 14</p> <p>When asked about the observation, the QMRP stated during interview on 11/6/09 from 1:50 - 3:45 p.m., formal and informal training as identified in his IPP and Medical and Social Assessment should have been implemented. The QMRP stated she believed the staff were nervous.</p> <p>4. Individual #5's IPP, dated 9/4/09, documented a 33 year old male diagnosed with profound mental retardation, intermittent explosive disorder, and anxiety disorder.</p> <p>Observations were conducted at the facility on 11/3/09 and 11/4/09 for a cumulative 4 hours 23 minutes during the day shift with the following results:</p> <p>a. An observation was conducted on 11/3/09 from 1:50 - 2:47 p.m. During that time, Individual #5 was not observed to participate in skill-building or meaningful activity as follows:</p> <p>1:50 - 1:55 p.m.: Individual #5 was noted to be wandering around the living room.</p> <p>1:55 - 1:58 p.m.: Individual #5 went in to the medication room.</p> <p>1:58 - 2:11 p.m.: Individual #5 came out of the medication room, holding a magazine. He was noted to wander around the facility. At 2:01 p.m., he was noted to pick up a newspaper flyer from a table in the television room. He continued to wander around the facility, holding the flyer.</p> <p>2:11 - 2:17 p.m.: Individual #5 was verbally prompted to get his coat from his bedroom, which</p>	W 196			

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W 196	<p>Continued From page 15</p> <p>he did. He returned to the dining area where staff adjusted his coat. He wandered in the area until 2:17 p.m., when he went outside in the back yard. He was noted to sit on the swing with staff accompaniment.</p> <p>2:23 - 2:30 p.m.: Individual #5 returned inside. He went to the living room, spit on the floor two times, and then proceeded to wander around the facility. At 2:25 p.m., he was verbally prompted to put a shirt on a hanger, which he did (10 seconds). Individual #5 proceeded to wander around the facility.</p> <p>2:30 - 2:43 p.m.: Individual #5 was prompted to trade in his paper tokens. Staff unlocked the reinforcer cabinet and Individual #5 chose a radio. He took the radio to his bedroom and closed the door.</p> <p>2:43 - 2:47 p.m.: Individual #5 came in to the kitchen. With verbal prompting, he obtained a jar of peanut butter and a butter knife and placed them on the counter (30 seconds). He stood at the counter while a staff person made him a sandwich. At 2:45 p.m., he sat at the dining table and ate his sandwich. He was verbally prompted to get a glass of milk, which he did. He returned and sat at the table, drinking his milk. He was not noted to be prompted or encouraged to wash his hands or assist in preparing his snack.</p> <p>During the 57 minute observation, Individual #5 was engaged in functional activity for a total of 19 minutes 40 seconds (administration of medications, swinging, listened to the radio, and ate his snack).</p> <p>When asked about the observation, the QMRP</p>	W 196			

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W 196	<p>Continued From page 16</p> <p>stated during interview on 11/6/09 from 1:50 - 3:45 p.m., all staff had been trained that "Every opportunity is a learning opportunity and individuals should be encouraged to participate in all activities of daily living to the fullest extent of their abilities." The QMRP stated formal and informal training as identified in his IPP and Medical and Social Assessment should have been implemented. The QMRP stated she believed the staff were nervous.</p> <p>b. An observation was conducted on 11/4/09 from 7:34 - 9:00 a.m. During that time, Individual #5 was not observed to participate in skill-building or meaningful activity as follows:</p> <p>7:34 - 7:37 a.m.: Individual #5 was noted to be in the television room. He was verbally prompted to go to the bathroom and wash his hands, which he did. At 7:36 a.m., he was verbally prompted to get a glass of water and go to the medication room, which he did.</p> <p>7:37 - 7:47 a.m.: Individual #5 took his medications.</p> <p>7:47 - 7:52 a.m.: Individual #5 left the medication room and went in his bedroom with a staff. At 7:48 a.m., he came out of his room and wandered around the facility.</p> <p>7:52 - 7:58 a.m.: Individual #5 sat at the dining table. After placing a serving of oatmeal in his bowl, he proceeded to eat.</p> <p>7:58 - 8:04 a.m.: Individual #5 was noted to have finished eating. He was verbally prompted to place his dishes in the sink and go change his shirt, which he did.</p>	W 196		

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W 196	<p>Continued From page 17</p> <p>8:04 - 8:44 a.m.: Individual #5 came out of his room and proceeded to wander around the facility.</p> <p>8:44 - 9:00 a.m.: Individual #5 was noted to lay on the television platform in the television room. At 8:46 a.m., a staff was noted to place a chair in the entrance such that Individual #5 could not leave the room. At 8:59 a.m., Individual #5 stood up and spit on the floor two times, then wandered around the room.</p> <p>During the 1 hour 26 minute observation, Individual #5 was engaged in functional activity for a total of 25 minutes (administration of medications, ate breakfast, and changed his shirt).</p> <p>When asked about the observation, the QMRP stated during interview on 11/6/09 from 1:50 - 3:45 p.m., formal and informal training as identified in his IPP and Medical and Social Assessment should have been implemented. The QMRP stated she believed the staff were nervous.</p> <p>c. An observation was conducted on 11/4/09 from 11:24 a.m. - 12:50 p.m. During that time, Individual #5 was not observed to participate in skill-building or meaningful activity as follows:</p> <p>11:24 - 11:28 a.m.: Individual #5 was noted to be wandering around the facility.</p> <p>11:28 - 11:35 a.m.: Individual #5 was verbally prompted to go to the living room and sit at the table to play a board game, which he did. He was verbally prompted to choose a game piece, which</p>	W 196			

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W 196	<p>Continued From page 18</p> <p>he did. He then stood and proceeded wander around the facility.</p> <p>11:35 - 11:43 a.m.: He returned to the table at 11:30 a.m. He was verbally prompted to move his game piece 3 spaces on the game board, which he did. He was noted to fold the game board and put it in its box. He stood and proceeded to wander between the living room, kitchen, and dining area.</p> <p>11:43 - 11:45 a.m.: Individual #5 obtained a glass of water with verbal prompts, and then went in to the medication room.</p> <p>11:45 a.m. - 12:04 p.m.: Individual #5 came out of the medication room and proceeded to wander around the facility. At 11:52 a.m., he was noted to spit on the floor in the foyer area, then continued to wander.</p> <p>12:04 - 12:07 p.m.: Individual #5 was prompted to go outside and swing with a staff person, which he did.</p> <p>12:07 - 12:11 p.m.: Individual #5 came back inside and stood in the dining area. At 12:08 p.m., he was verbally prompted to put a gallon of milk on the dining table, which he did. He walked in to the television room and wandered around the room. At 12:10 p.m., he was prompted to take plates, utensils, glasses, and napkins to the table in the living room, which he did. He placed the items on the table in a random fashion, and then continued to wander around the facility.</p> <p>12:11 - 12:17 p.m.: Individual #5 was noted to wander around the facility. At 12:17 p.m., he was prompted to sit at the table in the living room,</p>	W 196		

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W 196	<p>Continued From page 19</p> <p>which he did. Lunch items were placed on the table by staff.</p> <p>12:17 - 12:32 p.m.: Individual #5 was noted to place a serving of macaroni and cheese, a hot dog, fruit cocktail, and yogurt on his plate. He proceeded to eat lunch. He was not noted to be prompted or encouraged to wash his hands or assist in preparing his lunch.</p> <p>12:32 - 12:35 p.m.: Individual #5 was noted to have finished his lunch. He took his dishes to the kitchen sink and then went in to the bathroom with verbally prompting to do so.</p> <p>12:35 - 12:38 p.m.: Individual #5 came out of the bathroom and proceeded to wander around the facility.</p> <p>12:38 - 12:47 p.m.: Individual #5 was physically assisted to wipe his place at the table and then continued to wander.</p> <p>12:47 - 12:50 p.m.: Individual #5 sat at the table in the television room, next to a staff person. The staff person was noted to ask him questions about his favorite activities and eating establishments and wrote his responses on a piece of paper for him.</p> <p>During the 86 minute observation, Individual #5 was engaged in functional activity for a total of 27 minutes (administration of medications, swinging, set table, used the restroom, wiped his place at the table, and answered questions related to preferred activities and eating establishments).</p> <p>When asked about the observation, the QMRP stated during interview on 11/6/09 from 1:50 -</p>	W 196			

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W 196	Continued From page 20 3:45 p.m., The QMRP stated formal and informal training as identified in his IPP and Medical and Social Assessment should have been implemented. The QMRP stated she believed the staff were nervous.	W 196			
W 249	5. Refer to W249 as it relates to the facility's failure to ensure each individual received training and services consistent with their IPPs. 483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure each individual received training and services consistent with their IPPs for 4 of 5 individuals (Individuals #1, #2, #4 and #5) whose IPPs and training programs were reviewed. This resulted in individuals not receiving training as specified in their IPPs. The findings include: 1. Individual #1's IPP, dated 7/8/09, documented a 27 year old female diagnosed with profound mental retardation, autism, seizure disorder, and left hemiparesis. a. Individual #1's fluid intake program, dated 7/22/09, stated staff were to offer her fluids	W 249	W249 Programs were changed and updated to clarify program intent and implementaton. Staff trained to run programs as directed to ensure active treatment is assured. Para Q and QMRP responsible by 11/24/09 Staff trained to implement training programs to meet IPP goals and ensure active treatment. Programs to be review by Q and QA reviews monthly and at least quaterly. Observations to be made by Para Q, Q, Program Director, and other professional staff at least weekly using PSRs. Corrections to be made immediately with staff. PSRs to be reviewed during Monthly QA review. QMRP responsdible by 12/11/09		

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NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - ARMGA			STREET ADDRESS, CITY, STATE, ZIP CODE 12306 WEST ARMGA DRIVE MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 249	<p>Continued From page 21 throughout the day to prevent constipation.</p> <p>During observations on 11/3/09 and 11/4/09 for a cumulative 4 hours 23 minutes during the day shift, Individual #1 was not noted to be offered fluids. Individual #1's fluid intake program was not implemented as written.</p> <p>b. Individual #1's hygiene hand washing program, dated 7/22/09, stated staff were to cue her to wash her hands at appropriate times.</p> <p>During an observation on 11/3/09 from 4:30 - 5:30 p.m., Individual #1 was observed to eat dinner. Staff were not observed to cue Individual #1 to wash her hands prior to the meal.</p> <p>During an observation on 11/4/09 from 11:26 - 12:50 p.m., Individual #1 was observed to eat lunch. Staff were not observed to cue Individual #1 to wash her hands prior to the meal. Individual #1's hygiene hand washing program was not implemented as written.</p> <p>c. Individual #1's Daily Living Skills program, dated 7/8/09, stated staff were to cue her to join in activities throughout the day. Additionally, her Daytreatment Schedule, dated 10/09, showed she was to be offered activities every 15 to 20 minutes to encourage her to socialize.</p> <p>During observations on 11/3/09 and 11/4/09 for a cumulative 4 hours 23 minutes during the day shift, Individual #1 was not noted to be cued to join in activities. Her Daily Living Skills program was not noted to be implemented as written.</p> <p>d. Individual #1's eating program, dated 7/22/09, stated staff were to sit next to her. Further, her</p>	W 249			

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NAME OF PROVIDER OR SUPPLIER

TOMORROW'S HOPE - ARMGA

STREET ADDRESS, CITY, STATE, ZIP CODE

**12306 WEST ARMGA DRIVE
MERIDIAN, ID 83642**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	<p>Continued From page 22</p> <p>Daytreatment Schedule, dated 10/09, showed her eating program was to be implemented during all meals.</p> <p>During an observation on 11/4/09 from 11:26 a.m. - 12:50 p.m., Individual #1 was noted to eat lunch and staff were not noted to sit next to her. Individual #1's eating program was not implemented as written.</p> <p>e. Individual #1's Occupational Therapy program, dated 7/8/09, stated staff were to encourage her to use her left hand including be cued to reach up and give staff high fives throughout the day.</p> <p>During observations on 11/3/09 and 11/4/09 for a cumulative 4 hours 23 minutes during the day shift, Individual #1 was not noted to be encouraged to use her left hand. Her Occupational Therapy program was not noted to be implemented as written.</p> <p>f. Individual #1's Physical Therapy program, dated 7/8/09, stated staff were to encourage her to use her left hand and engage her in a physical activity such as dancing, walking, and exercising.</p> <p>During observations on 11/3/09 and 11/4/09 for a cumulative 4 hours 23 minutes during the day shift, Individual #1 was not noted to be encouraged to use her left hand or engage in physical activities. Her Physical Therapy program was not noted to be implemented as written.</p> <p>When asked, the QMRP stated during an interview on 11/6/09 from 1:50 - 3:45 p.m., staff were to implement the above noted objectives and services as written and when opportunities presented themselves.</p>	W 249		

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W 249	<p>Continued From page 23</p> <p>2. Individual #2's IPP, dated 3/26/09, documented a 27 year old male diagnosed with moderate mental retardation, autism, cerebral palsy, Fetal Alcohol Syndrome, and seizure disorder.</p> <p>a. Individual #2's communication program, updated 7/14/09, stated staff were to ask him questions and offer items throughout the day, allowing him the opportunity to say yes or no. The program stated he required multiple prompts to communicate.</p> <p>On 11/3/09 at 2:43 p.m., staff were noted to offer Individual #2 toast and coffee one time. He did not respond. The staff was not noted to repeat the offer. Individual #2's communication program was not implemented as written. Further, his Daytreatment Schedule, dated 10/09, stated he was to be offered several choices of snacks. Individual #2 was not noted to be offered snack choices.</p> <p>On 11/4/09 at 8:33 a.m., Individual #2 was offered a bowl of oatmeal. He did not respond. The staff was not noted to repeat the offer. Individual #2's communication program was not implemented as written.</p> <p>During the remainder of the observations conducted at the facility, on 11/3/09 and 11/4/09 for a cumulative 4 hours 23 minutes during the day shift, staff were not observed to implement Individual #2's communication program.</p> <p>b. Individual #2's eating program, dated 3/26/09, stated staff were to sit next to him at all times when eating. Additionally, his Daytreatment Schedule, dated 10/09, stated staff were to sit</p>	W 249			

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W 249	<p>Continued From page 24 next to him whenever he ate.</p> <p>During an observation on 11/4/09 from 11:24 a.m. - 12:50 p.m., Individual #2 was observed to eat lunch. Staff was noted to sit across the table from Individual #2. Individual #2's eating program was not implemented as written.</p> <p>c. Individual #2's pre-vocational skills program, dated 4/2/09, stated staff were to use verbal cues and physical prompts to have him sit at the table and work. During observations conducted at the facility on 11/3/09 and 11/4/09 for a cumulative 4 hours 23 minutes during the day shift, staff were not observed to implement Individual #2's pre-vocational skills program.</p> <p>d. Individual #2's physical therapy program, dated 3/26/09, stated staff were to encourage him to go for a walk. Further, his Daytreatment Schedule, dated 10/09, stated he was to be encouraged to participate in physical activities. During observations conducted at the facility on 11/3/09 and 11/4/09 for a cumulative 4 hours 23 minutes during the day shift, staff were not observed to implement Individual #2's physical therapy program.</p> <p>When asked, the QMRP stated during an interview on 11/6/09 from 1:50 - 3:45 p.m., staff were to implement the above noted objectives and services as written and when opportunities presented themselves.</p> <p>3. Individual #4's IPP, dated 9/11/09, documented a 28 year old male diagnosed with profound mental retardation, ADHD, and autism.</p> <p>a. Individual #4's eating skills program for napkin</p>	W 249			

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W 249	<p>Continued From page 25</p> <p>use, dated 9/11/09, stated staff were to cue him to use his napkin to wipe his hands or face during meals.</p> <p>During an observation on 11/3/09 from 1:50 - 2:47 p.m., Individual #4 was observed to eat a snack. A napkin was offered to him upon completion. Individual #4's napkin use program was not implemented as written.</p> <p>During an observation on 11/4/09 from 11:24 a.m. - 12:50 p.m., Individual #4 was observed to eat lunch. He was not consistently prompted to use his napkin. Individual #4's napkin use program was not implemented as written.</p> <p>b. Individual #4's eating skills program for pacing, dated 9/24/09, stated if he attempted to put food in his mouth before finishing the previous bite, staff were to cue him to slow down.</p> <p>During an observation on 11/3/09 from 1:50 - 2:47 p.m., Individual #4 was observed to rapidly eat his snack with no prompts to slow down. Individual #4's eating program was not implemented as written.</p> <p>During an observation on 11/4/09 from 11:24 a.m. - 12:50 p.m., Individual #4 was observed to rapidly eat lunch with no prompts to slow down. Individual #4's eating program was not implemented as written.</p> <p>c. Individual #4's communication program, dated 9/11/09, stated staff were to ask him to sign food or drink when he opened the refrigerator.</p> <p>During observations conducted at the facility on 11/3/09 and 11/4/09 for a cumulative 4 hours 23</p>	W 249			

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NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - ARMGA	STREET ADDRESS, CITY, STATE, ZIP CODE 12306 WEST ARMGA DRIVE MERIDIAN, ID 83642
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W 249	<p>Continued From page 26</p> <p>minutes during the day shift, Individual #4 was noted to periodically open and close the refrigerator door (no less than 4 times) while wandering through the kitchen. Staff were not noted to ask him to sign food or drink. Individual #4's communication program was not implemented as written.</p> <p>d. Individual #4's hygiene program, dated 9/24/09, stated staff were to cue him to wash his hands at appropriate times.</p> <p>During an observation on 11/3/09 from 1:50 - 2:47 p.m., Individual #4 was observed to eat a snack. Staff were not observed to cue Individual #4 to wash his hands prior to, or following, his snack. Individual #4's hygiene program was not implemented as written.</p> <p>During an observation on 11/4/09 from 11:24 a.m. - 12:50 p.m., Individual #4 was observed to eat lunch. Staff were not observed to cue Individual #4 to wash his hands prior to, or following, the meal. Individual #4's hygiene program was not implemented as written.</p> <p>When asked, the QMRP stated during an interview on 11/6/09 from 1:50 - 3:45 p.m., staff were to implement the above noted objectives and services as written and when opportunities presented themselves.</p> <p>4. Individual #5's IPP, dated 9/4/09, documented a 33 year old male diagnosed with profound mental retardation, intermittent explosive disorder, and anxiety disorder.</p> <p>a. Individual #5's inappropriate spitting program, dated 9/21/09, stated staff were to cue him to spit</p>	W 249		

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W 249	<p>Continued From page 27</p> <p>in the garbage rather than other places.</p> <p>During observations conducted at the facility on 11/3/09 and 11/4/09 for a cumulative 4 hours 23 minutes during the day shift, Individual #5 was noted to spit on the floor no less than 4 times. Staff were not noted to prompt Individual #5 to spit in the garbage can. Individual #5's inappropriate spitting program was not implemented as written.</p> <p>b. Individual #5's sign language program, dated 9/4/09, stated staff were to use simple signs when they prompted him throughout the day, and allow him to respond with sign when asked a question or offered choices.</p> <p>During observations conducted at the facility on 11/3/09 and 11/4/09 for a cumulative 4 hours 23 minutes during the day shift, staff were noted to verbally prompt Individual #5 to get his coat, put a shirt on a hanger, trade in tokens, obtain a jar of peanut butter, get a glass of milk, go to the bathroom, get water, go to the medication room, sit at the table, and move a game piece. Staff were not noted to use simple signs when they prompted him. Individual #5's sign language program was not implemented as written.</p> <p>c. Individual #5's eating program, dated 9/21/09, stated staff were to sit next to him. Individual #5 was noted to eat a peanut butter sandwich with milk on 11/3/04 at 2:43 p.m., and oatmeal on 11/4/09 at 7:52 a.m. During that time, staff were not noted to sit next to him. Individual #5's eating program was not implemented as written.</p> <p>d. Individual #5's eating pacing self program, dated 9/4/09, stated staff were to sit next to him</p>	W 249			

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W 249	Continued From page 28 and ensure he swallowed food in his mouth before taking a second bite. Individual #5 was noted to eat a peanut butter sandwich with milk on 11/3/04 at 2:43 p.m., and oatmeal on 11/4/09 at 7:52 a.m. During that time, staff were not noted to sit next to him. Individual #5's eating pacing self program was not implemented as written. When asked, the QMRP stated during an interview on 11/6/09 from 1:50 - 3:45 p.m., staff were to implement the above noted objectives and services as written and when opportunities presented themselves. The facility failed to ensure programs were implemented as written and when opportunities presented themselves for Individuals #1, #2, #4, and #5.	W 249			
W 391	483.460(m)(2)(ii) DRUG LABELING The facility must remove from use drug containers with worn, illegible, or missing labels. This STANDARD is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure drug containers with missing labels were removed from the facility for 2 of 6 individuals (Individuals #2 and #3) residing at the facility. This resulted in the potential for individuals to not be administered medication as ordered by their physician. The findings include: 1. On 11/4/09 at 8:15 a.m., Individual #2 was noted to place a tab of Calcium Citrate in his pill cup. It was noted there was no identifying information on the bottle. When asked, the staff	W 391	W391: Pharmacy immediately supplied labels to meet requirements Nurse responsible by 11/24/09 Nurse coordinated with pharmacy the need to ensure all medication containers have proper labeling to meet requirements. Nurse to check medication during medication placement and staff trained to review medications during shift cross overs to ensure requirements are met. Documentation to be made on Medication Accountability Sheet to be reviewed at least weekly by nurse. Nurse responsible by 12/11/09		

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W 391	Continued From page 29 person assisting with medications was unable to locate the box which contained Individual #2's name or pharmacy label. Additionally, on 11/4/09 at 7:15 a.m., Individual #3 was noted to apply Clindamycin (a topical lotion for acne) 1% to his face. It was noted there was no identifying information on the bottle of lotion. When asked, the staff person assisting with medications was unable to locate the box which contained Individual #3's name or pharmacy label. When asked, the LPN stated during an interview on 11/6/09 from 1:50 - 3:45 p.m., identifying information for the topical treatment and medication would be obtained that day (11/4/09). At 12:41 p.m., the LPN returned with the identifying information and stated the regular pharmacist was on vacation and the fill-in pharmacist was not aware of the need to identify the individuals' medications. The facility failed to ensure all treatments and medications contained appropriate identifying information.	W 391			
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure infection control procedures were followed to prevent and control infection and/or communicable diseases for 5 of 6 individuals (Individuals #1, #2, #3, #4,	W 455	W455. Staff trained on infection control protocols. Nurse to review survey with staf to discuss what corrective actions needed to be done to ensure proper hygiene and infection control protocol. Nurse responsible by 11/24/09 Staff to be trained on a continuum by nurse, Para Q and QMRP. Training to occur during weekly observations and on floor training. Observations to be added to PSR. PSRs to be reviewed during monthly QA reviews.		

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W 455	<p>Continued From page 30</p> <p>and #5) residing in the facility. This had the potential to provide opportunities for cross-contamination to occur and negatively impact individuals' health. The findings include:</p> <p>1. On 11/4/09 at 8:15 a.m., Individual #2's nose was noted to be dripping. He was noted to use his left hand and wipe it in a downward fashion such that it covered his lips and chin. He was not offered a tissue. Then using hand over hand assistance, he used his inhaler (Advair).</p> <p>His nose dripped a second time, and again, he used his left hand to wipe it in a downward fashion such that it covered his lips and chin. He was not offered a tissue. Then using hand over hand assistance, he used his nasal spray (Nasacort). He left the medication room at 8:33 a.m.</p> <p>It was noted the two treatments were put back in Individual #2's medication bin without being sanitized. Neither Individual #2 nor the staff were noted to wash their hands.</p> <p>When asked, the QMRP stated during an interview on 11/6/09 from 1:50 - 3:45 p.m., Individual #2 should have been offered a tissue and both Individual #2 and the staff should have washed their hands afterwards.</p> <p>2. Observations were conducted in the facility on 11/3/09 and 11/4/09 for a cumulative 4 hours 23 minutes during the day shift. During that time, breakfast, lunch, and afternoon snack were observed. Individuals #1, #2, #4, and #5 were not noted to be prompted or encouraged to wash their hands prior to eating.</p>	W 455			

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NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - ARMGA			STREET ADDRESS, CITY, STATE, ZIP CODE 12306 WEST ARMGA DRIVE MERIDIAN, ID 83642		
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W 455	<p>Continued From page 31</p> <p>When asked, the QMRP stated during an interview on 11/6/09 from 1:50 - 3:45 p.m., all individuals should have been prompted or encouraged to wash their hands prior to eating.</p> <p>3. On 11/4/09 at 7:15 a.m., Individual #3 was observed taking his medications. It was noted that he dropped his Century Vitamin on the floor. With a verbal prompt, he picked it up from the floor, added it to his pill cup, and then took his medications (that were in the pill cup) with water.</p> <p>When asked, the staff person assisting with medications stated he was told if a pill dropped on the floor, the individual could pick it up and take it. When asked, the LPN stated during an interview on 11/6/09 from 1:50 - 3:45 p.m., the staff person was nervous and was trained to dispose of the medication and call her (the LPN).</p> <p>4. On 11/4/09 at 7:37 a.m., Individual #5 was observed taking his medications. It was noted that he dropped his Dairy Relief pill on the floor. With a verbal prompt, he picked it up from the floor, added it to his pill cup, and then took his medications (that were in the pill cup) with water.</p> <p>When asked, the staff person assisting with medications stated he was told if a pill dropped on the floor, the individual could pick it up and take it. When asked, the LPN stated during an interview on 11/6/09 from 1:50 - 3:45 p.m., the staff person was nervous and was trained to dispose of the medication and call her (the LPN).</p> <p>The facility failed to ensure infection control procedures were appropriately implemented.</p>	W 455			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/09/2009
NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - ARMGA		STREET ADDRESS, CITY, STATE, ZIP CODE 12306 WEST ARMGA DRIVE MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM212	16.03.11.075.17(a) Maximize Developmental Potential The treatment, services, and habilitation for each resident must be designed to maximize the developmental potential of the resident and must be provided in the setting that is least restrictive of the resident's personal liberties; and This Rule is not met as evidenced by: Refer to W195, W196, and W249.	MM212	MM212 Refer to W195, W196, and W249	
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept clean and in good repair, and every reasonable precaution was taken to prevent the entrance of insects for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include: 1. During an environmental assessment on 11/5/09 from 3:33 - 4:28 p.m.. the following issues were noted: Living Room: - The screens were pulled away from the windows. - A panel of the wood flooring was noted to move	MM380	MM380 All deficiencies to be repaired, cleaned, or replace as need to meet requirements. Para Q and Maintenance responsible by 12/11/09 Maintenance list to include the deficiencies and Para Q and/or Maintenance to review at least monthly. Maintenance list to be reviewed at Monthly QA and corrections needed added to action list to be followed up on by next QA Para Q and Maintenance responsible by 12/11/09 RECEIVED DEC 01 2009 FACILITY STANDARDS	

Bureau of Facility Standards

Thair Pond, Administrator 11/24/09

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

5899

EXC711

If continuation sheet 1 of 3

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/09/2009
NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - ARMGA			STREET ADDRESS, CITY, STATE, ZIP CODE 12306 WEST ARMGA DRIVE MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
MM380	Continued From page 1 back and forth; it was not secured to the floor. Television room: - The screens were pulled away from the windows. - The wall nearest to the medication room had areas of missing paint. Kitchen: - There were three cookie sheets that contained baked-on grease. - The toaster contained food debris and was noted to be greasy. Individual #1's Bedroom: - The top left drawer was missing from her dresser. Individual #2 and #4's Bedroom: - The screen was pulled away from the window. - Individual #2's hygiene kit contained spilled shampoo. Back Bathroom: - The floor vent contained rust. - The left side of the floor vent was noted to be pushed under the vinyl flooring. - The blue floor rug contained a 6 inch tear.	MM380			
MM512	16.03.11.200 Administration The administration of ICF/MR facilities must provide for individual program planning, implementation and evaluation. Individual programs must be based on relevant assessment of needs and problems and must reflect the participation of the individual, the service providers, and where possible, the individual's family or surrogate. Individual program planning must include provisions for total program	MM512	MM512 Refer to W100		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/09/2009
NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - ARMGA			STREET ADDRESS, CITY, STATE, ZIP CODE 12306 WEST ARMGA DRIVE MERIDIAN, ID 83642		
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MM512	Continued From page 2 coordination and continuous, self-correcting processes for review and program revision. Programming for individuals must incorporate the resident's legal rights of due process, appropriate care, training and treatment. This Rule is not met as evidenced by: Refer to W100.	MM512			
MM758	16.03.11.270.02(f)(iv) Medication System Monitored The resident's medication system must be evaluated and monitored on a regular basis by a registered nurse and/or a licensed pharmacist. Such evaluations must be done at least every thirty (30) days and records of the evaluation, as well as action taken to correct noted problems, must be kept on file by the facility administrator. This Rule is not met as evidenced by: Refer to W391.	MM758	MM758 Refer to Tag W391		
MM769	16.03.11.270.03(c)(vi) Control of Communicable Diseases and Infectio Control of communicable diseases and infections through identification, assessment, reporting to medical authorities and implementation of appropriate protective and preventative measures. This Rule is not met as evidenced by: Refer to W455.	MM769	MM769 Refer to Tag W455		